STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Michigan
POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)

11/01/94 The cost limit is applied by each subprovider within a hospital at the time of hospital settlement. The Medicaid outpatient payment by subprovider is limited to a maximum of the Medicaid costs for that subprovider. The cost limit test is applied to all payments including the outpatient share of direct medical education but excluding any special indigent pool payments.

11/01/94 Aggregate Medicaid reimbursement to Michigan outpatient hospitals (including the special indigent pools) will not be allowed to exceed the federally imposed upper limit for outpatient services provided to Michigan recipients. To account for varying hospital year end dates, this test will be made annually based on hospital fiscal years ending during the State fiscal year (e.g. the test for 1995 will use hospital years ending between October 1, 1994 and September 30, 1995). If the test against the upper limit was exceeded, the size of the special indigent pool will be reduced by the amount in excess of the limit.

Between October 1, 1994, and March 31, 1995, qualifying children's hospitals will share in an outpatient adjustor pool of $347,550. These payments will be in addition to the regular indigent column and indirect education adjustments normally included as part of the fee screen based payments. Eligibility for the pool is restricted to freestanding children's hospitals as defined for the purpose of the Medicaid Indigent Volume Report (Medical Assistance Program, Hospital Manual, Chapter VIII, page 19, item#3). Indigent volume charges and children's hospital status will be determined from the Medicaid Indigent Volume Report for hospital fiscal years (FY) ending between October 1, 1992 and September 30, 1993. To be eligible a children's hospital must have incurred outpatient indigent volume charges (for hospital fiscal years ending between October 1, 1992 and September 30, 1993) in excess of $34,000,000. These data have been subject to review and appeal and will not be changed. Each eligible hospital will share in the pool proportionately using the ratio of the hospital's FY 1995 Title XIX estimated outpatient charges to the sum of FY 1995 Title XIX estimated outpatient charges for qualifying hospitals.

The $347,550 will be paid on or after October 1, 1994, provided that the Michigan Department of Public Health transfers $150,000 to the Michigan Department of Social Services. When additional funds of $347,550 (for a FY 1995 total of $695,100) are appropriated for the time period covering April 1, 1995 through September 30, 1995, and after the Michigan Department of Public Health transfers another $150,000 to the Michigan Department of Social Services, an additional installment of $347,550 will be paid to qualifying children's hospitals. When appropriated, the second installment of $347,550 will be paid on or after April 1, 1995. These payments will be made based on the best data available.

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10/01/94 Payments made during FY 1995 will be estimated payments and will be adjusted to a final amount based on actual amount paid for state fiscal year 1995, as of December 31, 1996, excluding direct medical education payments and payments from this pool. The paid claims include Title XIX and Title V/XIX paid claims from provider types 40, 41 and 75.

10/01/94 For purposes of this pool, Medicaid outpatient hospital reimbursement to any single hospital will be allowed to exceed the hospital's Medicaid outpatient charges and Medicaid payments may exceed a hospital's outpatient Medicaid cost. The special indigent payments made under this provision will be exempt from the outpatient hospital charge and cost limits.

The State collaborates with the Michigan Department of Public Health (MDPH) on a Vaccine Replacement Program (VRP). Vaccines are provided free to enrolled Medicaid providers on a replacement basis to immunize Medicaid eligible. Providers are reimbursed an enhanced administration fee to encourage their participation. The department reimburses the MDPH the government price for each dose of vaccine administered, in addition to a per dose handling fee and spoilage allowance. Providers may also request the manufacturer's cost of vaccine if they elect not to participate in the VRP. The department establishes the reimbursement rate for purchased vaccine by allowing the lowest most commonly available cost to purchase the product in multiple dose units plus a nominal administration fee.

Outpatient hospital psoriasis treatment centers are reimbursed a rate based on estimated and historical costs of psoriasis treatment centers certified by the Medical Services Administration. Reimbursement will be the lesser of the hospital's charges or the established Medicaid rate for the treatment episode. The rate includes all services that may be provided to the recipient, except physician services. Physician services are reimbursed separately as clinic visits. Outpatient hospital psoriasis services rendered to recipients who do not meet the specified admission criteria for the psoriasis treatment centers are reimbursed under the current fee for service system.

4. Home Health Agency Services
   Reimbursement to home health agencies is made in accordance with Medicaid's maximum fee screens or the home health agency's usual and customary charge (acquisition cost for medical supply items), whichever amount is less.

5. Rural Health Clinic Services
   Payments for "provider clinics" will be on the basis of Medicare regulations in part 405, support D, 42 CFR. Payments for non "provider clinics" will be based on the Medicare cost rate per visit for rural health clinic services. Payment for other ambulatory services will be made on the basis of reasonable charges, as defined in 1. above.

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6. Optical House Services

Payment for optical house services will be on the basis of contracted prices established in conformance with federal procurement policies. Optical houses will be reimbursed only for materials. Providers furnishing materials obtained from an optical house under contract with the State will be reimbursed only for the services involved in dispensing such materials. Payment rates for these services are based on "reasonable" charges, as defined in #1 above.

7. Personal Care Services in a Recipient's Home

Reimbursement is made according to variable rates, depending upon the setting of service delivery, payment levels determined by policy or the legislature, and recipient needs.

Basic rates for personal care services provided in recipients' own homes are established within the nominal maximum of $333 per month as established by Medicaid policy. A Medicaid –approved case manager performs an assessment of the recipient's needs, determines the amount of care required, and negotiates the best rate possible, given the prevailing local wage structure. The Medicaid agency allows designated local agencies to make exceptions to the $333 monthly rate, up to $999 per month, if a recipient's needs are extensive or intensive enough to require more, or more costly, services. For cases exceeding $999 per month, decisions are made by the single state agency, considering documented need and potential alternative placements.

For recipients in general, adult foster care facilities or homes for the aged, a flat monthly rate is established annually by the state legislature for those Medicaid eligibles who, according to a standardized assessment, have a documented need for personal care services. There is no specific rate methodology or inflation factor applied during the legislative rate establishment. Recipients whose needs exceed the services available via the flat rate methodology are identified through the standardized assessment and the development of a care plan. This information becomes the basis for decisions on exceptions.

For recipients in specialized foster care facilities operated under the auspices of a public mental health agency, daily rates for personal care are based on a work measurement study. The percentage of staff time devoted to personal care is multiplied by the hourly rate of staff costs. Annual reevaluations of the specialized facility rates are made, based on changes in wage structures for this type of facility. Preliminary fee screens are adjusted to final once each year. Placement of recipients in these specialized facilities is predicated on the use of a standardized assessment of personal care needs. Recipients in these settings have documented needs higher than those in general foster care.

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8. Mental Health Clinic Services

Reimbursement for mental health clinic services will be on a fee-for-service basis. Payment will be the lesser of charge or fee screen. When there are comparable services offered by other provider types, fee screens will be established at comparable levels. Preliminary fee screens are adjusted to final once each year. For those services delivered as part of a comprehensive program of service, providers will be paid one of two hourly rates which reflect the portion of covered services delivered in the total program.

9. Case Management Services

Reimbursement will be on a fee-for service, billed on a monthly basis. Payment will be the lesser of charge or fee screen, with the single state agency assuring the reasonableness of the charges. For mental health, preliminary fee screens are adjusted to final once each year.

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REIMBURSEMENT

10. Hospice Services

Medicaid will use the Medicaid rates established by the Health Care Financing Administration and apply the appropriate local wage index for the categories of care provided. The "appropriate local wage index" is the index indicated for the recipient's county of residence.

Direct patient care provided by the hospice medical director, hospice employed physician, or consulting physician must be billed by the hospice, using the appropriate Health Care Financing Administration Common Procedure Coding System code(s), and will be reimbursed at the applicable Medicaid fee screen.

If the recipient is residing in a Medicaid enrolled nursing facility or alternative intermediate services (AIS) home, Medicaid will pay the room and board amount using the percentage established by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) to the hospice, and the hospice will reimburse the facility. This applies to Medicare/Medicaid recipients as well as Medicaid only recipients.

11. Maternal Support Services

Reimbursement for maternal support services will be on a fee-for-service basis, within Medicaid established frequency limits, to agencies that have been certified by the Michigan Department of Public Health as qualified to provide these services. Payment will be the lesser of the charge or fee screens established by the department. Fee screens are established relative to similar services reimbursed by the department.

12. Ambulatory Uterine Activity Monitors

Reimbursement for the ambulatory uterine activity monitor is through a per diem rate. All equipment, perinatal nursing services, technical services and supplies necessary for the provision of the monitor are considered included in this rate. The per diem rate is the lesser of the single state agency's fee screen or the provider's usual and customary charge minus any third party payment. Providers' charges and other states' Medicaid fee screens are utilized as guidelines or reference in determining the fee screen.

Medications and physician professional services that are appropriate for a recipient using a monitor are separately reimbursable. Payment for these medications and services will be in accordance with the methods described under "Drug Products" and "Individual Practitioner Services."

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13. Rehabilitation Services

a. Rehabilitation Services for Neurological Damage

Reimbursement for rehabilitation services for persons with neurological damage will be according to per diem, individually priced, negotiated rates which reflect the service needs and a reasonable cost basis for the services rendered. Reimbursement will exclude payment for room and board, educational and vocational services.

b. Mental Health Community Rehabilitation Services

Reimbursement for mental health community rehabilitation services will be on a fee-for-service basis. Payment will be the lesser of charge or fee screen. Preliminary fee screens are adjusted to final once each year. When there are comparable services offered by other provider types, fee screens will be established at comparable levels.

c. Substance Abuse Treatment Rehabilitation Services

Reimbursement for substance abuse treatment rehabilitation services will be on a fee-for-service basis. Payment will be the lesser of charge of fee screen. Preliminary fee screens are adjusted to final once each year. When there are compatible services offered by other provider types, fee screens will be established at comparable levels.

d. Mental Health Psychosocial Rehabilitation Programs (PSR)

The Medicaid-covered components of PSR are reimbursed as a package using one procedure code for the total components. The rate was established at the 90th percentile of the cost range of existing PSR programs based n a survey of those programs. Providers will be reimbursed the lesser of charge of the established fee screen. Preliminary fee screens are adjusted to final once each year.

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The uniform fee schedule may be adjusted annually, either upward or downward, based on the DRI medical inflation index. Adjustment of the uniform fee schedule sill not result in reimbursement rates below the amount necessary for an economic and efficient provider to operate.

The payment differential between individual and group service rates is based on Medicare RBRVS RVU's as published in the November 25, 1991, Federal Register.

13f) INTENSIVE/CRISIS RESIDENTIAL SERVICES

Reimbursement will be the provider's usual and customary charge to the general public or a maximum allowable cost, on a per diem basis, whichever is less. Preliminary fee screens are adjusted to final once each year. The per diem rate will be an inclusive rate for the covered services provided in the residential setting. Separate rates will be established for persons who attend out of home day programs and those who do not. Medicaid will not pay for room, board, and routine supervision for any crisis residential participant.

13g) INTENSIVE/CRISIS STABLILIZATION SERVICES

Reimbursement will be the provider's usual and customary charge to the general public or a maximum allowable cost, whichever is less. Preliminary fee screens are adjusted to final once each year. The reimbursement rate will be an inclusive rate for the covered services provided during the crisis stabilization service, and will be based on a half-hour of intensive/crisis stabilization services.

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14. **Federally Qualified Health Center Services**

Centers signing a Memorandum of Agreement (MOA) will receive the lessor of actual cost or the Medicaid limit for primary care services including dental and maternal support and infant support services. The Medicaid limit for Centers signing the MOA is the annual Medicare Federally Qualified Health Center (FQHC) upper payment limit plus an add-on rate of $17.00. In the case of a Center that operates with a fiscal year that overlaps two calendar years, a rate is calculated by taking the average of the Medicaid limit (i.e. Medicare FQHC upper payment limit plus an add-on rate of $17.00) for the two Calendar years. In calendar year 2001, the $17.00 add-on rate will be adjusted by the percentage change in the Medicare Economic Index (MEI) from the year 2000. For each FQHC's subsequent fiscal year, the MEI will be applied to the previous year's add-on rate. In addition, these Centers will receive reasonable full cost for transportation and outreach.

Centers that do not sign the MOA will receive the lessor of actual costs or the Medicaid limit for primary care services. The Medicaid limit for Centers not signing the MOA is 95 percent of the annual Medicare FQHC upper payment limit for the center's fiscal years 2000-2002, 90 percent of the limit for fiscal year 2003, and 85 percent of the limit for fiscal year 2004. Costs for transportation, outreach, dental, and maternal and infant support services are reimbursed at reasonable full cost, adjusted by the applicable percentages identified in this paragraph.

For both MOA and non-MOA Centers, the covered services will be reimbursed by the applicable Medicare cost reimbursement principles detailed in 42 CFR, Part 413.

Centers must supply the program with their Medicaid cost reports which list the medical costs, revenue, and encounters. Centers will receive quarterly interim payments. Cost settlements will be performed at the end of each center's fiscal year ending after April 1, 1990.

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15. **Public Clinic Services**

Reimbursement for Public Clinic Services is at reasonable and allowable full costs, as described below.

The methodology for achieving full cost reimbursement is fee for service billings which are subsequently cost settled. To participate in this methodology, qualified providers must supply the Program with a Medicaid cost report which lists medical costs, revenue, and encounters for services covered by this section. Based on the Medicaid cost report, a provider specific encounter rate is determined and used to make initial full-cost payments which are made on a quarterly basis, as applicable.

Annual cost settlements are performed to ensure that the initial payments were made at reasonable and allowable full cost. As necessitated by the cost settlement process, any financial adjustments are made with the provider. The settlements are performed for each public clinic and for each fiscal year which ends after April 1, 1991.

A combination of local funds and state general funds will provide the basis for reimbursing providers and for claiming federal financial participation in expenditures made pursuant to this section, per 42 CFR, 433.33.

Reasonableness and allowability of costs is determined by use of the applicable Medicare cost reimbursement principles detailed in 42 CFR, part 413.

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16. Other Services

Other services listed in Section 1905(a) of the act that are not heretofore described are reimbursed on the basis of reasonable charge, as defined in number 1 above.

Michigan will follow the procedures contained in Section 3006(B)(C) of the Medicare Carrier's Manual.